

Report
of the
Examination of
PHP Insurance Plan, Inc.
De Pere, Wisconsin
As of December 31, 2001

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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September 5, 2002

Honorable Connie L. O'Connell
Commissioner of Insurance
Madison, Wisconsin

Commissioner:

In accordance with your instructions, a compliance examination has been made of
the affairs and financial condition of:

PHP INSURANCE PLAN, INC.
De Pere, WI

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of PHP Insurance Plan, Inc., formerly known as Prevea Health Insurance Plan, Inc. (the HMO or PHP) was conducted in 1999 as of December 31, 1998. The current examination covered the intervening period ending December 31, 2001, and included a review of such 2002 transactions as deemed necessary to complete the examination.

The examination consisted of a review of all major phases of the HMO's operations, and included the following areas:

- History
- Management and Control
- Corporate Records
- Conflict of Interest
- Fidelity Bonds and Other Insurance
- Provider Contracts
- Territory and Plan of Operations
- Affiliated Companies
- Growth of the HMO
- Reinsurance
- Financial Statements
- Accounts and Records
- Data Processing

Emphasis was placed on the audit of those areas of the HMO's operations accorded a high priority by the examiner-in-charge when planning the examination. Special attention was given to the action taken by the HMO to satisfy the recommendations and comments made in the previous examination report.

The section of this report titled "Summary of Examination Results " contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comment on the remaining areas of the HMO's operations is contained in the examination work papers.

The HMO is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

PHP Insurance Plan, Inc. can be described as a for-profit group model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as "... a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618 that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the group model, the HMO contracts with a sponsoring clinic to provide primary and specialist services. HMOs compete with traditional fee-for-service health care delivery.

The HMO was incorporated October 23, 1996 under the name Prevea Health Insurance Plan, Inc., and commenced business in 1997. Wausau Service Corporation (WSC) and Prevea Health Services, Inc. (PHSI) contributed a total of \$1.5 million to the plan on November 13, 1996. From that time and for the majority of 2000 the HMO was two-thirds owned by Prevea Health Services, Inc. (PHSI) and one-third owned by Wausau Service Corporation (WSC).

A series of capital contributions from PHSI and the issuance of new common stock over 2000 and 2001 changed the ownership of the plan. The transactions were as follows:

- On December 20, 2000, PHSI made a capital contribution of \$1.8 million as a purchase of 12,340 shares of stock increasing their ownership to 93.5% and diluting WSC to 6.5%.
- On June 30, 2001 PHSI made another capital contribution of \$1.0 million to purchase 20,105 shares of Class A stock. After the purchase the plan was owned 97.2% by PHSI and 2.8% by WSC.
- On December 31, 2001 PHSI made a final stock transaction which resulted in PHSI 100% owner of the Plan. Prevea Health Insurance Plan, Inc. changed its name to PHP Insurance Plan, Inc. effective January 8, 2002.

The HMO contracts with 278 primary care and 1,454 specialty care providers. Prevea Clinic, owned by PHSI, accounts for approximately 40% of the HMO's primary care providers. Referrals must be preauthorized by an enrollee's primary care provider, except for the following services if performed by a participating practitioner: routine eye exams, removal of impacted wisdom teeth, chiropractic care, and behavioral health care.

The main provider agreement for Prevea is with PHSI. The provisions of the agreement are outlined below:

- Effective date: The original contract was signed in 1996, with four amendments being executed in subsequent periods.
- Services: PHSI agrees to arrange for the provision of medical services to members, of the same scope customarily provided to members of the public. Prevea and PHSI shall cooperate to establish guidelines for contract negotiations with payors, benefit plans, and providers.
- The contract includes an insolvency provision, under which PHSI agrees to continue to arrange for the provision of or pay for the medical services rendered to members prior to the insolvency of Prevea. Under the hold-harmless clause of the agreement, PHSI agrees not to bill members for services, other than for copayments, deductibles, and noncovered services.
- Term: Initial term through December 31, 2001; automatically renewing for additional one-year terms.
- Termination: (a) By either party giving 180 days' advance written notice prior to the end of a term.
- (b) For cause, immediately upon written notice, should a party continue in default of its responsibilities for 30 days after notice of default is received.
- Compensation: PHP makes direct payments to PHSI providers as outlined below:
- A. Prevea Clinic, Inc. (PCI) – For Medical Services provided to Members in the Year 2000 and forward, PHP or its designee will make PHSI Direct Payments to PCI, as PHSI Designee, the lesser of Charged Amount or Fee Schedule Amount minus any deductibles or coinsurance and withholds.
 - B. St. Mary's Hospital (SMH) and St. Vincent Hospital (SVH) – For Medical Services provided to Members in the year 2000, and forward PHP or its designee will make PHSI Direct Payments to SMH and SVH, as PHSI designees, in an amount equal to the discounted fee amount less any deductibles or coinsurance and withholds.

PHSI agrees to provide all Medical Services to members selecting PHSI as their primary provider for each year. The risk amount is calculated based on the claims target less capitated per member per month (pmpm) targets. If the risk amount exceeds the actual claim payments made, PHP will release amounts withheld to PHSI.

If the risk amount is less than the actual claim payments resulting in a deficit, PHP will apply amounts withheld to the deficit. Remaining withholds, if any, will be returned to PHSI. If the amount of the deficit exceeds amounts withheld, PHSI will pay PHP such amount.

PHP also contracts with other providers for the provision of primary and specialty care. The contracts generally have a one-year term and automatically renew for additional one-year terms. The contracts include hold-harmless provisions for the protection of

policyholders. Typically, contracts may be terminated by either party giving 60 days' written notice prior to the end of a contract term. Some contracts require 90 days' notice. The majority of providers are compensated based on the HMO's standard fee schedule, while some are paid on a discounted fee-for-service basis. Contracts also include a 20% withhold arrangement beginning in 2000.

The HMO contracts with eight hospitals to provide inpatient services, as listed below. Hospitals are reimbursed on a capitation, negotiated per diem, or discounted fee-for-service basis. The contracts include hold-harmless provisions for the protection of policyholders.

Contracting hospitals are:

- Bay Area Medical Center, Marinette
- Bellin Hospital, Green Bay
- Community Memorial Hospital, Oconto Falls
- Door County Memorial Hospital, Sturgeon Bay
- Holy Family Memorial Medical Center, Manitowoc
- Oconto Memorial Hospital, Oconto
- St. Mary's Hospital Medical Center, Green Bay
- St. Vincent Hospital, Green Bay

According to its business plan, the HMO's service area is comprised of the following counties:

Brown, Door, Kewaunee, Manitowoc, Marinette, and Oconto

The HMO offers comprehensive health care coverage that may be changed by riders to include deductibles and copayments. The following health care coverages are provided:

- Physician services
- Prescription drugs—copayment level varies by type (generic, brand formulary, non-formulary)
- Preventive health services
- Routine eye examinations
- Routine hearing examinations
- Inpatient services
- Outpatient services
- Emergency care
- Chiropractic services
- Mental health, drug, and alcohol abuse services
- Special dental procedures (oral surgery)
- Prosthetic devices and durable medical equipment
- Newborn services
- Home health care
- Diabetes treatment
- Convalescent nursing home service
- Cardiac rehabilitation, physical, speech, and/or occupational therapy

Hospice care
Kidney disease treatment
Certain transplants

Inpatient mental health and AODA coverage is limited to 10 days, transitional care is limited to 20 days, and outpatient mental health and AODA coverage is limited to 30 visits per year. Skilled nursing care is limited to 60 days. Plan coverage is contingent on nonemergency services being provided by participating physicians and hospitals or on the referral of participating physicians. Members are required to choose a primary care physician from the listing of participating physicians available. The HMO also offers point-of-service (POS) plans, under which a member may choose to seek services from nonparticipating providers, for higher co-payments and lesser levels of coverage.

The HMO currently markets principally to groups. PHP also markets an individual 65+ Medicare supplement product. The HMO uses a mixed distribution force consisting of selected agencies in the Northeastern Wisconsin/Fox Valley area. For the HMO's 65+ product a managing general agent is used, Informed Choice.

The HMO uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted for age/gender distribution, benefit plan, area, trend, and administrative cost on a group-by-group basis. Experience is reviewed for renewal groups; credibility factors are used to blend the "book" rate with the experience rate, giving more weight to the experience portion of the rate as the group size increases. Small groups are handled separately, using a rate tier system to recognize medical risk factors within the requirements set forth by the state.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of six members. Two directors are elected annually to serve a one-year term. Officers are elected by the board of directors. Members of the HMO's board of directors may also be members of other boards of directors in the holding HMO group. The board members do not receive compensation for serving on the board.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
James Coller De Pere, WI	Administrator – St. Mary's Hospital	2005
Robert Kaftan, M.D. De Pere, WI	President / CEO PHSI – Ashwaubenon site	2005
Gary Leach Springfield, IL	Vice President Fiscal and Corporate Services Hospital Sisters Health System	2004
James Memmen, M.D. Green Bay, WI	Ophthalmologist – Prevea Clinic	2004
Ron Menaker Green Bay, WI	Executive Vice President PHSI – Ashwaubenon site	2003
James Temp Green Bay, WI	Chairman – Aon Risk Services of WI, Inc.	2003

Officers of the Company

The officers elected by the board of directors and serving at the time of this examination are as follows:

Name	Office	2001 Salary
Mark Minsloff	President / CEO	\$215,500*
Ronald Menaker	Secretary	*
Karl Appleton	Treasurer	*

* The HMO does not have its own employees. Employees are compensated by Prevea Clinic.

Committees of the Board

The HMO's bylaws allow for the formation of certain committees by the board of directors. The committees at the time of the examination are listed below:

Executive Committee

Jim Collier, Chair
Mark Minsloff
Ron Menaker
G. Robert Kaftan

In addition PHP has the following management committees that report to the board:

Finance Committee
Marketing Committee (at the PHSI level)
Practitioner Advisory Committee
Medical Care Facilitation Committee

The HMO has no employees. Necessary staff is provided through a management agreement with Prevea Clinic, Inc. (PCI). Under the agreement, effective February 28, 2000, Prevea Clinic agrees to negotiate employer, provider, subscriber, and other contracts; advises the board; maintains accounting and financial records; recruits marketing, utilization review, and claims processing personnel; provides or contracts for claims processing, and MIS. PCI receives compensation within 10 days of the services rendered. The agreement remains in effect until December 31, 2002 and thereafter renews for one year terms. The contract does not discuss standards of performance for the clinic and a proper indemnification clause is not included. This is discussed further in the caption titled "Summary of Examination Results."

Financial Requirements

The financial requirements for an HMO under s. Ins 9.04, Wis. Adm. Code, are as follows:

	Amount Required
1. Minimum capital or permanent surplus	Either: \$750,000, if organized on or after July 1, 1989 or \$200,000, if organized prior to July 1, 1989
2. Compulsory surplus	The greater of \$750,000 or: If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months; If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months
3. Security surplus	The greater of: 140% of compulsory surplus reduced by 1% of compulsory surplus for each \$33 million of additional premiums earned in excess of \$10 million or 110% of compulsory surplus
4. Operating funds	Funds sufficient to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

In addition, there is a special deposit requirement equal to the lesser of the following:

1. An amount necessary to maintain a deposit equaling 1% of premium written in this state in the preceding calendar year;
2. One-third of 1% of premium written in this state in the preceding calendar year.

The HMO has satisfied this requirement for 2001 with a deposit of \$581,000 with the State Treasurer.

Insolvency Protection for Policyholders

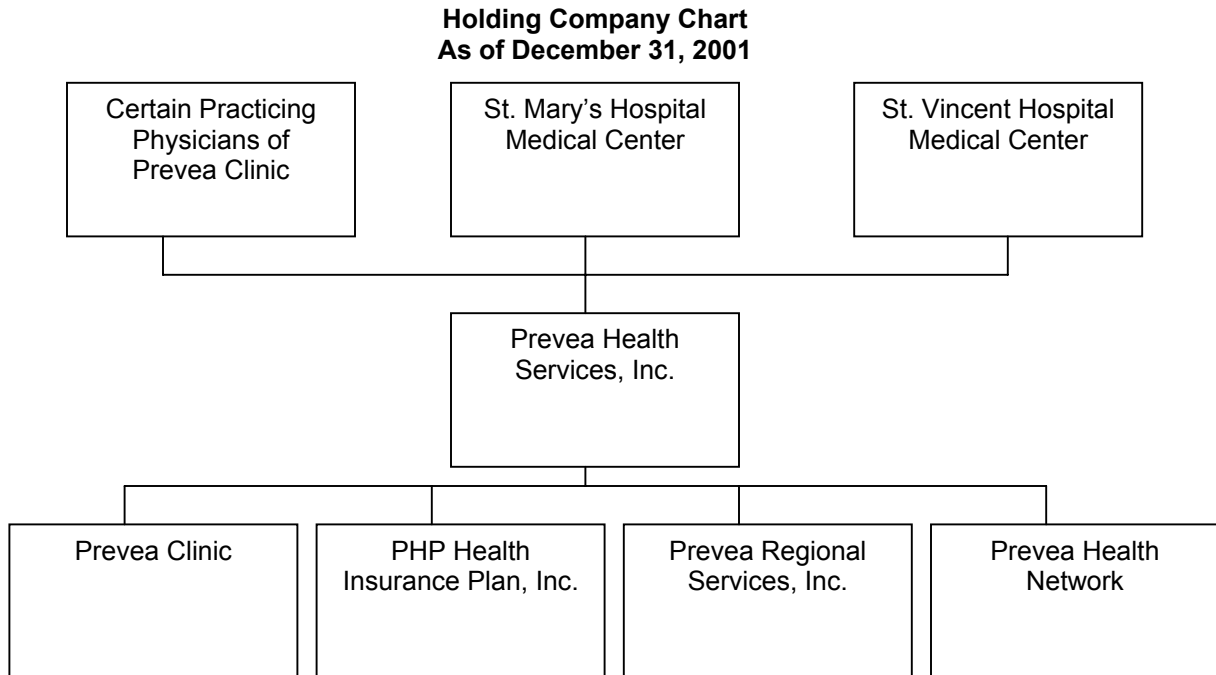
Under s. Ins 9.04, Wis. Adm. Code, HMOs are required to provide continuation of coverage for its enrollees. These requirements are the following:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

The HMO has not met this requirement, as discussed in the section of the report captioned "Summary of Current Examination Results."

IV. AFFILIATED COMPANIES

The HMO is a member of a holding company system. The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the HMO follows the organizational chart.



Prevea Health Systems, Inc. (PHSI)

Prevea Health Services, Inc. (PHSI), is a holding company. In addition to owning a majority interest in the HMO, PHSI owns Prevea Clinic, Prevea Health Network and Prevea Regional Services, Inc. As of December 31, 2001, the company's audited consolidated financial statements reported assets of \$85 million liabilities of \$38 million and stockholders' equity of \$47 million. Operations for 2001 produced a net loss of \$3 million on revenues of \$133 million.

Affiliated Agreements

The HMO has an agreement with Prevea Clinic in which the Clinic provides certain administrative services to PHP. These services include personnel, payroll, marketing, various miscellaneous services and making equipment available. Most services are paid based on their actual cost while others are allocated per a percentage. This agreement was not filed with OCI as further discussed in the section of this report captioned "Summary of Examination Results."

V. REINSURANCE AND CORPORATE INSURANCE

The HMO has reinsurance coverage under the contract outlined below:

Reinsurer:	Allianz Life Insurance Company of North America
Type:	Specific Excess of Loss Reinsurance
Effective date:	January 1, 2001
Retention:	\$100,000 hospital attachment point; Allianz will pay no more than \$2,000,000 in aggregate per member over all contract years.
	Covered Acute Care
	A. Any member if paid at a Fixed Fee or if not paid at a fixed fee 90%
	B. Related to organ, bone marrow or peripheral stem cell transplant(s) for the period of confinement in which the transplant occurs:
	1) If performed in the LifeTrac Network and paid at an Approved Transplant Rate 90%
	2) If performed outside the LifeTrac Network and paid at an Approved Transplant Rate 80%
	3) If paid at other than the above 50%
	4) If related to retransplantation of same tissue type performed within one year of the date of the initial transplant 50%
Coverage:	Commercial HMO and Commercial POS (in network only)
Premium:	Commercial HMO \$1.57 pmpm; Commercial POS \$1.31 pmpm
Termination:	End of contract year.

The reinsurance policy has an endorsement that states "upon the date the Plan is Insolvent, and so long as on that date or prior to that date a court has declared both St. Vincent's Hospital and Prevea Health Systems insolvent or bankrupt and both St. Vincent's Hospital and Prevea Health Systems has ceased all operation, then and only then, Allianz Life will provide the benefits" below:

1. Allianz Life will continue plan benefits for members who are confined in an acute-care hospital on the date of insolvency until their discharge.
2. Allianz Life will continue plan benefits for any member insured plan until the end of the contract period for which premiums have been paid to plan by that member or on his behalf.
3. Allianz Life will make available to all members for a period of 30 days, without evidence of insurability, a replacement coverage of the same benefit schedule and rates as then being offered by Allianz Life to other prospective insureds within the state.

This does not satisfy the provisions required by s. Ins. 9.04 (6), Wis. Adm. Code. This is discussed further in the section of the report captioned "Summary of Examination Results."

In addition, the HMO is provided with corporate insurance coverage under the contracts listed below:

Type of Coverage	Policy Limits
Directors' and officers' liability	\$ 4,000,000
Managed Care Errors and Omissions	4,000,000
	1,000,000 for Antitrust Activity
Fidelity Bond	600,000

The above coverages were obtained through CNA and Executive Risk Indemnity, which are licensed in Wisconsin.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the HMO as reported in the December 31, 2001, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the HMO for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Net Worth per Examination."

PHP Insurance Plans, Inc.
Assets
As of December 31, 2001

	Assets	Nonadmitted Assets	Net Admitted Assets
Cash and short-term investments	\$13,769,447	\$	\$13,769,447
Accident and health premiums due and unpaid	1,099,646		1,099,646
Health care receivables	298,294		298,294
Amounts recoverable from reinsurers	44,289		44,289
Investment income due and accrued	3,062		3,062
Prepays and deposits	<u>93,622</u>	<u>93,622</u>	<u>0</u>
Total assets	<u>\$15,308,460</u>	<u>\$93,622</u>	<u>\$15,214,738</u>

PHP Insurance Plans, Inc.
Liabilities and Net Worth
As of December 31, 2001

Claims unpaid		\$ 4,386,728
Unpaid claims adjustment expenses		248,890
Premiums received in advance		1,339,540
General expenses due or accrued		705,043
Amounts withheld or retained for the account of others		520,497
Amounts due to parent, subsidiaries and affiliates		<u>5,759,603</u>
Total liabilities		12,960,301
Gross paid in and contributed surplus	\$ 35,445	
Aggregate write-ins for other than special surplus funds	6,497,339	
Unassigned funds (surplus)	<u>(4,278,347)</u>	
Total capital and surplus		<u>2,254,437</u>
Total liabilities, capital and surplus		<u>\$15,214,738</u>

**PHP Insurance Plans, Inc.
Statement of Revenue and Expenses
For the Year 2001**

Net premium income		\$58,701,175
Change in unearned premium reserves and reserve for rate credits		<u>(622,281)</u>
Total revenues		58,078,894
Medical and Hospital:		
Hospital/medical benefits	\$46,405,605	
Outside referrals	2,508,411	
Emergency room and out-of-area	<u>3,344,548</u>	
Subtotal	52,258,564	
Net reinsurance recoveries	<u>109,376</u>	
Total medical and hospital	52,149,188	
Claims adjustment expenses	355,225	
General administrative expenses	<u>7,230,811</u>	
Total underwriting deductions		<u>59,735,224</u>
Net underwriting gain or (loss)		(1,656,330)
Net investment gains or (losses)		122,081
Miscellaneous income		<u>430,312</u>
Net income (loss)		<u><u>\$(1,103,937)</u></u>

**PHP Insurance Plans, Inc.
Capital and Surplus Account
As of December 31, 2001**

Capital and surplus prior reporting year		\$2,425,475
Net income or (loss)	(1,103,937)	
Change in nonadmitted assets	(93,517)	
Change in surplus notes	(239,701)	
Paid in capital	20,105	
Paid in surplus	<u>1,246,012</u>	
Net change in capital and surplus		<u>(171,038)</u>
Capital and surplus end of reporting year		<u><u>\$2,254,437</u></u>

PHP Insurance Plans, Inc.
Statement of Cash Flows
As of December 31, 2001

Cash from Operations

Premiums and revenues collected net of reinsurance	\$62,883,351
Claims and claims adjustment expenses	49,719,010
General administrative expenses paid	<u>9,156,402</u>
Cash from underwriting	4,007,939
Net investment income	<u>134,551</u>
Net cash from operations	4,142,490

Cash from Financing and Miscellaneous Sources

Cash provided:

Surplus notes, capital and surplus paid in	\$1,000,000
Net transfers from affiliates	<u>3,465,292</u>
Net cash from financing and miscellaneous sources	4,465,292
Net change in cash and short-term investments	8,607,782
Cash and short-term investments:	
Beginning of year	<u>5,161,664</u>
End of year	<u>\$13,769,446</u>

Growth of PHP Insurance Plans, Inc.

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2001	\$15,214,738	\$12,960,301	\$2,254,437	\$58,701,175	\$52,149,188	(\$1,103,937)
2000	7,463,082	5,037,607	2,425,475	48,466,687	44,970,811	(2,511,535)
1999	7,266,900	4,852,778	2,414,122	40,826,773	35,644,988	(226,553)
1998	4,170,122	3,012,825	1,157,297	30,892,822	26,624,640	97,158

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2001	-1.90%	89.80%	12.90%	0.6%
2000	-5.09	92.80	13.90	-0.3%
1999	-0.55	87.30	14.00	15.3%
1998	0.31	86.18	13.96	249.4%

Enrollment and Utilization

Year	Commercial Enrollment	Hospital Days/1,000	Average Length of Stay
2001	28,011	215.51	3.2
2000	27,831	269.13	3.0
1999	27,907	205.68	2.8
1998	24,203	219.16	3.7

Per Member Per Month Information

	2001	2000	Percentage Change
Premiums:			
Commercial	<u>\$178.61</u>	<u>\$146.73</u>	21.7%
Expenses:			
Hospital/medical benefits	142.71	120.74	18.2
Outside referrals	7.71	6.61	16.8
Emergency room and out-of-area	10.29	8.81	16.8
Less: Net reinsurance recoveries	<u>0.34</u>	<u>0.00</u>	
Total medical and hospital	160.37	136.15	17.8
Claims adjustment expenses	1.09	0.00	
General administrative expenses	<u>22.24</u>	<u>20.80</u>	6.9
Total underwriting deductions	<u>\$183.70</u>	<u>\$156.95</u>	17.0

The HMO has increased its earned premium by 90% since 1998. However, the increase in revenues has also brought on increased expenses. The HMO's expenses have been larger than revenues, therefore leading to net losses for the last three years.

Assets and liabilities increased 103% and 158% from 2000 respectively. This is primarily due to the cash and claims payable account increases from the claims backlog created when the HMO switched administrators in July 2001 from Employers Insurance of Wausau (Wausau) to The Trizetto Group, Inc. (Trizetto), an information technology and services company focused on the healthcare industry. The backlog had a more significant affect on the claims payable due to the level of conservatism in the claims payable. The HMO purported that due to the fluctuations in claim payments between the normal payment patterns through July 2001 and the erratic payment patterns from August 2001 through December 2001, it made it difficult to determine completion factors and reserves. The reserve estimates at 12/31/01 were extremely conservative due the uncertainty with the fluctuations. As the HMO has analyzed 2002 claim data it was noted claim payment patterns have stabilized and approximately \$2 million of the 2001 reserves were released due to being excess reserves.

Reconciliation of Capital and Surplus per Examination

The following schedule is a reconciliation of capital and surplus between that reported by the HMO and as determined by this examination:

Capital and surplus December 31, 2001, per annual statement			\$2,254,437
Examination Adjustments:	Increase	Decrease	
Amounts due from affiliates	\$	\$ (692,909)	
Net increase or (decrease)	<u>\$</u>	<u>\$ (692,909)</u>	<u>(692,909)</u>
Capital and surplus December 31, 2001, per examination			<u>\$1,561,528</u>

Examination Reclassifications

	Debit	Credit
Amounts Withheld for others	\$ 520,497	
Amounts due to affiliates		\$1,213,406
Amounts due from affiliates	<u>692,909</u>	<u></u>
Total reclassifications	<u>\$1,213,406</u>	<u>\$1,213,406</u>

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were twelve specific comments and recommendations in the previous examination report. Comments and recommendations contained in the last examination report and actions taken by the HMO are as follows:

1. Articles and By-Laws—It is recommended that the HMO comply with its articles of incorporation concerning the terms for members of its board of directors.

Action—Partial Compliance. The HMO did not comply with this recommendation in 2001, however, it appears it had to do with the restructuring. The HMO did comply with this recommendation in 2002.
2. Articles and By-Laws—It is recommended that the HMO hold meetings of its shareholders on an annual basis, as required by its by-laws.

Action—Partial Compliance. The HMO did not comply with this recommendation in 2001, however, it appears it had to do with the restructuring. The HMO did comply with this recommendation in 2002.
3. Management and Control—It is recommended that the HMO establish a procedure so that conflict of interest statements are completed each year by directors, officers, and key staff members, in accordance with the directive of the Commissioner of Insurance.

Action—Partial Compliance. The HMO did not comply with this recommendation in 2001, however, it appears it had to do with the restructuring. The HMO did comply with this recommendation in 2002.
4. Management and Control—It is recommended that the HMO submit biographical information on newly elected officers and directors in a timely fashion, as required by s. Ins 6.52 (5), Wis. Adm. Code.

Action—Non-compliance
5. Management and Control—It is recommended that the HMO file all material changes in its affiliated agreements with OCI, as required by s. Ins 3.50 (6), Wis. Adm. Code and s. 611.67 (3), Wis. Stat.

Action—Non-compliance
6. Claims Payable—It is recommended that the HMO timely settle affiliated balances, in accordance with the terms of its written agreements.

Action—Non-compliance
7. Agents—It is recommended that the HMO accept business only from properly listed agents pursuant to s. Ins 6.57 (5), Wis. Adm. Code.

Action—Non-compliance

8. Affiliated Companies—It is recommended that the HMO comply with the requirements of ch. Ins 40, Wis. Adm. Code.

Action—Non-Compliance

9. Affiliated Companies—It is recommended that the HMO properly complete Schedule Y in future statutory financial statement filings.

Action—Non-compliance

10. Affiliated Companies—It is recommended that the HMO properly nonadmit amounts due from affiliates, as required by s. Ins 3.50 (8m), Wis. Adm. Code, in future statutory financial statement filings.

Action—Non-compliance

11. Disaster Recovery Plan—it is recommended that the board formally acknowledge and document its acceptance of EIW's disaster recovery/contingency plans.

Action—Compliance

12. Insolvency Provisions—It is recommended that the HMO comply with s. Ins 3.50 (4) (e), Wis. Adm. Code.

Action—Non-compliance

Summary of Current Examination Results

Management and Control

Biographical sketches of an insurer's directors and officers are required to be filed with the Commissioner's office within 15 days of the election or appointment of such, under s. Ins 6.52 (5), Wis. Adm. Code. Examination review indicated that biographical information was not on file for one current director and one officer. It is again recommended that the HMO submit biographical information on newly elected officers and directors in a timely fashion, as required by s. Ins 6.52 (5), Wis. Adm. Code. (Note: Subsequent to fieldwork the HMO submitted biographical information for all directors and officers.)

The HMO did not file financial information electronically with the NAIC for 2001 and the first quarter of 2002 as required. It was apparent that the HMO was unaware of this filing requirement despite the fact that it is clearly disclosed in the annual statement packets posted on the OCI website. The HMO should have been aware of this requirement if they read the packet. The HMO has also received letters regarding this filing requirement from the OCI. It is recommended that the HMO establish a procedure to file its information with the NAIC. (Note: Subsequent to fieldwork the HMO did submit the 2002 second quarter statement to the NAIC.)

The HMO has been late with its annual and quarterly filings with the OCI. In some instances the HMO was granted an extension and was still late after the OCI had granted the HMO the extension. It is recommended that the HMO establish procedures to submit the required filings to the OCI on a timely basis. (Note: Subsequent to fieldwork the second quarter statement for 2002 was received on time.)

Bylaws

The HMO went through a restructuring at the end of 2001. This restructuring was approved by the OCI. Pursuant to s. 611.12(4), Wis. Stat., bylaws should be filed within 60 days after adoption. These bylaws were not filed at the time of fieldwork. It is recommended the HMO file changes to its bylaws with the OCI pursuant to s. 611.12(4), Wis. Stat. (Note: Subsequent to fieldwork the HMO filed the bylaws.)

Corporate Records

The HMO has an executive committee that meets as needed. Review of the committee minutes during fieldwork indicated that there were not minutes to the executive committee from 2000 to the present. When these minutes were requested during fieldwork management responded that the executive committee is a group of executives in the PHSI and PHP management structure that meet as needed to go over strategic issues. They purported that this was not a committee that is organized in the bylaws so minutes were not taken in 2000 – 2002. Review of the bylaws for the period indicated that an executive committee is defined in the bylaws and was supposed to meet monthly one week prior to the BOD meeting. The HMO should be retaining corporate records, such as minute books as required by s. Ins. 6.80(4), Wis. Adm. Code. It is recommended that the HMO take minutes at Executive Committee meetings and retain such minutes as permanent records pursuant to s. Ins. 6.80, Wis. Adm. Code.

Territory and Operations

The HMO listed Shawano County on its annual statement as a service area. It was noted that Shawano was originally listed on some reports by Wausau and that it was not until the HMO was verifying information this year that it was realized the HMO was never authorized to market in Shawano County. It is recommended that the HMO develop a procedure to ensure correct reporting of its service area.

Insolvency Protection

Pursuant to s. Ins. 9.04(6), Wis. Adm. Code a health maintenance organization is required to either maintain compulsory surplus as required for other insurers under s. 51.80, Wis. Adm. Code or to demonstrate that in the event of insolvency all the following will be met:

- (1) Enrollees hospitalized on the date of insolvency will be covered until discharged.
- (2) Enrollees will be entitled to similar, alternate coverage that does not contain any medical underwriting or pre-existing limitation requirements.

An HMO usually demonstrates this coverage in its reinsurance contract. The HMO's reinsurance contract states that this coverage is only provided if St. Vincent's Hospital and Prevea Health Systems, Inc. (PHSI) are insolvent and bankrupt. This does not adequately

address the insolvency requirements of s. Ins 9.04(6), Wis. Adm. Code since it is dependent on the insolvency of the other organizations. It is again recommended that the HMO comply with s. Ins. 9.04(6), Wis. Adm. Code.

Business Plan

Section Ins. 9.06, Wis. Adm. Code, states that “the insurer may not enter into any transaction, contract, amendment to a transaction or contract or take action to make any omission that is a substantial change in the insurer’s business plan prior to the effective date of the change or if the change is disapproved.” Section Ins. 9.06, Wis. Adm. Code further defines substantial changes to “include changes in articles and bylaws, organization type, geographical service areas, provider agreements, provider availability, plan administration, financial projections and guarantees and any other changes that might affect the financial solvency of the plan.”

During the examination period the HMO entered in to the following transactions that warranted business plan filings:

- The HMO paid PCI a prepayment of \$500,000 for services, which should have been in the provider agreement.
- The risk sharing arrangement in the PHSI provider agreement was amended many times and was not filed with the OCI.

Since these transactions affected PHP’s provider agreements, specifically related to financial arrangements that may affect the solvency of the HMO, a change of business plan should have been filed with the OCI pursuant to s. Ins. 9.06, Wis. Adm. Code. It is recommended that the HMO file an amendment to its business plan within thirty-days of the adoption of this report. Further, it is recommended that the HMO comply with business plan filings required by s. Ins. 9.06, Wis. Adm. Code in the future.

Holding Company

Under ch. Ins 40, Wis. Adm. Code, an insurer that is a member of a holding company system is required to annually file a holding company registration statement (Form B) and summary of registration statement (Form C) by June 1. The HMO did not file a Form B, registration statement for 2001. Upon inquiry the HMO responded incorrectly that the filing

requirement was not applicable. It is again recommended that the HMO comply with the requirements of ch. Ins. 40, Wis. Adm. Code.

As part of a holding company structure, the HMO is required to file prior notice of a transaction (Form D), which are subject to disapproval by the OCI. Pursuant to s. Ins. 40.04, Wis. Adm. Code all management agreements, exclusive agency agreements, service contracts or cost-sharing arrangements are required to be reported. In addition, transactions not in the ordinary course of the business that involve a domestic insurer and an affiliate shall also be filed if it involves or exposes to risk an amount equal to or exceeding the lesser of 2% of the domestic insurer's admitted assets or 10% of policyholder surplus. The HMO did not file the following agreements/transactions with the OCI during the examination period:

- In 2000, the HMO transferred to Prevea Health Network (PHN), an affiliated company, all its ASO contracts. This transaction was not filed with the OCI.
- The HMO entered into an agreement with Prevea Clinic, Inc. (PCI), in which PCI provides services and equipment to PHP. This agreement was not filed with the OCI.
- The HMO made an advance to the Clinic for services under a risk arrangement. For further discussion on this advance see "Affiliated Transactions" in this section of the report.

It is recommended that the HMO comply with Form D filings in the future pursuant to s. Ins. 40.04, Wis. Adm. Code.

The HMO did not complete Schedule Y – Part 1 or Part 2 correctly. Schedule Y – Part 1 requires the HMO to insert an organization chart of the holding company structure. The HMO provided a holding company chart, however, the organization chart was not correct. Understanding the holding company structure for the organization is a basic responsibility. Without this knowledge the HMO cannot possibly evaluate their place in the structure and appropriately report balances in Schedule Y – Part 2. The schedule described PHSI as a joint venture among Prevea Clinic, St. Mary's Hospital and St. Vincent Hospital, when in fact, Prevea Clinic is a subsidiary of PHSI. Part 2 of the schedule is to provide a summary of the HMO's transactions with any affiliates. In the December 31, 2001, annual statement, PHP reported its service contract and reinsurance agreements with Employers Insurance of Wausau, but no information was reported pertaining to the provider services agreement with PHSI. It is again

recommended that the HMO properly complete Schedule Y in future statutory financial statement filings.

Affiliated Agreements

PHP files a consolidated tax return with its parent PHSI. There is no agreement in place for filing this consolidated tax return. Statement of Statutory Accounting Principle (SSAP) No. 10 requires that all intercompany income tax transactions should be supported by a written income tax allocation agreement. It is recommended that the HMO draft a formalized income tax allocation agreement with PHSI pursuant to SSAP No. 10 and file this agreement with the OCI pursuant to s. Ins 40.04, Wis. Adm. Code, within sixty days of adoption of this report.

The HMO has entered into an administrative service arrangement with PHN, which is not substantiated by an agreement. Payroll costs are charged back to PHP from Prevea Clinic. PHP then does an allocation of the salaries and benefits based on the FTE splits between PHP and PHN. The PHN salaries are part of a monthly allocation from PHP. Based on the FTE splits, occupancy costs such as rent, postage and supplies are allocated as a percentage to PHN each month. Salaries and these allocated occupancy costs make up PHN's allocation amounts. Per the company there are minimal direct expenses incurred by PHN and most of their expenses are through the allocation process, since PHN does not have a checkbook. Any direct expenses for PHN are paid by PHP and ran through the inter-company account. It is recommended the HMO draft formalized agreements for services provided.

PHP entered into an agreement for Services and Equipment with Prevea Clinic. The agreement does not contain standards of performance and there is a limitation on the liability in the indemnity clause. This limitation reads that "under no circumstances shall PCI be liable to PHIP¹ for any lost profits, incidental or consequential damages claimed to arise out of the failure of PCI to perform this Agreement." Section 617.21, Wis. Stat., requires transactions between an insurer and its affiliates to be reasonable and fair to the interests of the insurer. It is questionable whether this particular agreement is fair to the interests of PHP since the agreement has a one-sided indemnification clause and includes no standards for performance. It is recommended that

¹ PHP is referred to as PHIP in the agreement

the HMO amend its Services and Equipment agreement with the Prevea Clinic in order to bring the transaction into compliance with s. 617.21, Wis. Stat.

Affiliated Transactions

Examination of affiliated balances led to the following exceptions. The HMO reported an Amount withheld on account of others of \$520,497. This balance consisted of withholds in the amount of \$1,020,597 to PHSI offset by an advance to Prevea Clinic of \$500,000. The amount of the withholds payable to PHSI was reclassified to amounts due to affiliates. The Clinic prepayment of \$500,000 was reclassified to amounts due from affiliates.

The HMO did not properly classify all affiliated balances as amounts due to or from affiliates. An insurer may net debit and credit balances as long as the contract specifically allows for the offset of such balances. The examination determined that the HMO had payable and receivable balances with Wausau and PHSI. These amounts should have been netted on the annual statement for reporting purposes. This led to a net amount payable to PHSI of \$4.9 million and a net receivable amount from Wausau of \$79 thousand. This change as well as the other amounts already reported on the annual statement resulted in a balance of \$192,909 being reclassified to amounts due from affiliates.

In 2000, the risk arrangement between PCI and PHP changed from a direct capitation arrangement to a back-end capitation arrangement. In the new arrangement, claims were paid on a FFS basis and were compared to the premium funding available to determine if there should be a receivable from the Clinic for the deficit or payable to the clinic for surplus. Since there was a time delay in getting payment to the Clinic when they switched to FFS, a prepayment of \$400,000 was made to Prevea Clinic in January 2000. In March 2000, an additional prepayment of \$100,000 was made to Prevea Clinic. The HMO purported that Wausau staff discussed this issue with OCI at the time of the cash transfers and were told that these amounts would be an offset to the funds held by company line on the statutory statement. No formal agreement has been executed regarding these prepayments. Per the HMO the Clinic Prepayment will be settled in third quarter of 2002 as part of the settlement process of the 2001 risk arrangement. SSAP No. 25 provides that an advance to a related party should be

nonadmitted if they do not constitute an arm's-length transaction. This transaction did not constitute an arm's-length transaction since there was not an agreement.

The examination decreased surplus by \$692,909, which consisted of the \$192,909 reclass and the \$500,000 clinic prepayment, to properly non-admit the amounts due from affiliates pursuant to s. Ins 9.10, Wis. Adm. Code. It is again recommended that the HMO properly nonadmit amounts due from affiliates, as required by s. Ins 9.10, Wis. Adm. Code, in future statutory financial statement filings.

Under a risk-sharing component of a provider agreement with PHSI, discussed in the section of this report captioned "History and Operations," PHP should calculate the amount under the risk arrangement following a six-month run out at the end of each calendar year-end. A report of such calculation shall be sent to PHSI by July 30 and payments are to be made within 30 days of this calculation. To date the amount under the 2001 risk arrangement has not been settled. It is again recommended that the HMO timely settle affiliated balances, in accordance with the terms of its written agreements.

Financial Reporting

The HMO did not complete supporting schedules in the annual statement correctly.

The following errors were noted during the examination:

- The HMO reported amounts in Exhibit 6 and 7 as amounts due from and payable to affiliates. However, when the HMO reported the amounts on the balance sheet the amount was reported as a net payable. The HMO is allowed to offset receivables and payables with an affiliate if offsetting is provided for in the contract. However, the HMO cannot net all payables and receivables.
- Schedule S – Part 3 – Section 2 did not include the amount of reinsurance ceded under the POS contract with Wausau and did not trace to the underwriting and investment exhibit.

It is recommended the HMO properly complete schedules in accordance with the NAIC Annual Statement Instructions for Health Insurers on future statutory statements.

Cash

During the examination period, the HMO started receiving a new type of bank statement for their general account from the bank. This bank statement would automatically produce a list of outstanding checks and reconcile the bank balance to the HMO's book balance.

This reconciliation is dependent upon the submission of checks as they are issued to the bank in order to produce the list of outstanding checks. Trizetto, the HMO's administrator, was responsible for sending a list of all checks issued to the bank. From July to December, this list of checks issued was not submitted to the bank on time and the HMO had no procedures in place to verify whether the lists were submitted or not. Therefore, the HMO was unable to reconcile the balance on the bank statement to the HMO's book balance. The checks which were cleared but had not been submitted on a timely basis to the bank were recorded as issued but not recorded (INNR) on the bank statement. These INNR checks would drop off the bank statement regardless of whether the bank had received the list of issued checks or not, making it very difficult to track them. Per discussion with the HMO, there are now procedures in place to ensure Trizetto is submitting the list of checks issued on a timely basis. However, the HMO was still unable to provide a listing of all outstanding checks to date. In order to reconcile the HMO's bank balance to its book balance the HMO makes bulk adjustments to the listing of outstanding checks provided from the bank. The HMO then uses a plug figure to get the balance to reconcile. An accurate reconciliation of cash cannot be performed using information provided during the examination. It is recommended that the HMO reconcile its general account and produce a list of outstanding checks to this office within 60 days of adoption of this report.

The HMO does not have a formal procedure in place for reporting abandoned property to the state under ch. 177, Wis. Stat. The HMO purports that the oldest outstanding checks date back to 1998. However, since the HMO was unable to provide a list of outstanding checks, the examination was unable to verify this. If there are checks outstanding from 1998, the five-year mark for reporting them to the state is approaching. It is recommended that the HMO set up a procedure for keeping track of checks that could be escheatable under ch. 177, Wis. Stat.

The HMO has also entered into a Repurchase / InvestAccount Sweep Agreement with the bank. Funds are transferred from the HMO's general account nightly to the InvestAccount. Funds in the InvestAccount are pooled with other companies' funds that are transferred to this account. It was noted that the HMO receives a statement daily via e-mail that

discloses the Cusip numbers of the investments the HMO funds are being invested in. However, the repurchase agreement does not specify what type of securities the funds have to be invested in once they go into the InvestAccount. Also, the bank is unable to provide confirmation for the amount in PHP's name because the funds are in a pooled account. Section 610.23, Wis. Stat., requires insurers to hold funds in their own name or under a custodial agreement or trust arrangement with a bank or banking and trust company. This investment is in violation of this statute since there is no custodial or trust agreement. The amount of the investment at year-end totaled \$14,585,310. An adjustment was not made to the HMO's cash for purposes of this examination, however it is imperative the HMO remedy this situation. It is recommended that the HMO comply with s. 601.23, Wis. Stat., by holding funds in its own name or under the terms of an acceptable custodial arrangement.

In addition, the \$14,585,310 investment in the repurchase agreement as of December 31, 2001, exceeded the class limitation for investments in assets of a single issuer and its affiliates (10% of assets) prescribed in s. 620.23(2)(b), Wis. Stat. The HMO may include investments not specifically prohibited by statute, to the extent of not more than 5% of the first \$500,000,000 of the insurer's assets plus 10% of the insurer's assets exceeding \$500,000,000 for compulsory and security surplus calculations pursuant to s. 620.22(9), Wis. Stat. (the "basket" clause). Section 620.21, Wis. Stat., states that the amount of the investment exceeding the limitations cannot be counted toward satisfying the compulsory and security surplus requirement. Therefore, the amount of the investment in excess of 15% of assets (the 10% limitation plus the 5% "basket" clause) should be deducted from the insurer's assets when calculating compulsory surplus. Excluding the portion of the investment that exceeds the limits set forth above would have given the HMO a compulsory deficit at December 31, 2001. An adjustment was not made to the compulsory surplus calculation for purposes of this examination; rather the HMO will be given an opportunity to remedy the situation. It is recommended that the HMO develop a plan that outlines how the HMO will comply with compulsory surplus requirements for future filings and file the plan with this office within sixty days of adoption of this report.

Investment Plan

The HMO does not have a formal investment plan. As noted previously, the HMO is investing in the "InvestAccount", which is in violation of s. 610.23, Wis. Stat. Discussion with company personnel noted that the HMO is working on Investment Plan at this time. It is recommended that the HMO finalize a formal investment plan that complies with state statutes and submit it to this office for review within 60 days of adoption of this report.

Premium

Trizetto is responsible for all premium billing and premium receivable collections, as well as the maintenance and production of the Premium Receivable Aging Report. Trizetto produces bills on the 18th of each month for the following month. Bills are sent to PHP to be checked and then Trizetto makes the changes and sends out the bills. Premium is due from the group by the 1st of the month. If payment is not received by the 1st the group has until the end of the month to pay without risk of termination. Premium is recorded on the Premium Receivable Aging Report the date the bill is mailed.

Groups send payments to the lockbox account or wire them to the bank. Trizetto then applies this payment to the receivable balance using the "first in-first out" (FIFO) method. No reconciliation is done between the amount paid by the group and the amount billed. All cash is applied to the oldest amount even if the payment is for the current period. This method is not the appropriate method to use under statutory guidance. It is recommended that the HMO discontinue the use of the FIFO method for applying cash received from groups as well as reconcile its billed amounts to amounts paid by its groups to determine the correct receivable balance and to properly age premiums receivable.

The HMO has a practice of setting up an allowance for its premium greater than 120 days. Guidance is provided in SSAP No. 6 that states an insurer should nonadmit any uncollected premium over 90 days. After the calculation of nonadmitted amounts, an evaluation shall be made of the remaining assets in accordance with SSAP No. 5 to determine impairment. If it is probable the balance is uncollectible any uncollectible receivable shall be written off and charged to income in the period the determination is made. It is recommended that the HMO

discontinues using an allowance for doubtful accounts and nonadmit premium receivable balances over 90 days.

Testing of the advance premium balance provided that the amount on the annual statement consisted of \$1.2 million, which was supported by company records, and \$94 thousand, which was plugged in as a variance. During the examination the HMO was unable to provide detail records of this amount however, the following explanation was received from the HMO on this amount. The HMO purported that of the variance, \$16,454 is for COBRA premium for Wausau Benefits groups that went into Prevea's (n/k/a PHP) M&I account but was not accounted for. The remaining variance is for 65+ members for premium that was received for new members for which bills were not generated until July 2002 when the HMO transitioned from Trizetto to CHCS Services, Inc. Since there was not billed premium to match the receipts against, the amounts stayed in advance premium. Without the detail records the examination was unable to verify the amounts and determine if they were correctly reported. It is recommended the HMO maintain proper premium records pursuant to s. Ins 6.80(4), Wis. Adm. Code. The examination will not adjust the reported balance due to the immateriality of the amount.

Agents

Commission testing provided that an agent receiving commission was not a licensed agent with the OCI. The HMO purported that they relied on Wausau's agent licensing department to list the agents. It is again recommended that the HMO accept business only from properly listed agents pursuant to s. Ins 6.57 (5), Wis. Adm. Code.

Claims

Trizetto began to process claims for the HMO in August 2001. For the months prior in 2001, Wausau was the administrator. All the paid claims data was transferred to Trizetto. When these claims were transferred no reconciliation was performed to ensure that information was not lost in the transfer. Therefore, the paid claim report received from Trizetto for months prior to August 2001 did not trace to claim lag triangles. Further testing also provided that the

amounts on the lag triangle did not match claim fund report summaries the HMO obtained from Wausau.

The examination was unable to reconcile the paid claim reports to the general ledger for the months January through July of 2001. The HMO purported that when Wausau handled the claims processing function, the claims used for reserves and the fund report needed to match. Wausau obtained paid claim data from the DataScan system. The claim data from another system were loaded into DataScan but without cents. The cents were dropped off of each claim as it was loaded so the variances between the paid claim reports and the lag tables are due to truncating of the claims. When Wausau originally switched to the new risk method and needed to pull amounts out of DataScan, a reconciliation was done between the other system and DataScan in order to ensure that the same claim data were being used in both systems and no differences existed other than those caused by truncating. The HMO did not retain any of the detail reports on the Wausau claims or the reconciliations done by Wausau. The absence of these reports made it impossible for the examination to trace the paid claims to the general ledger without material variances for the months January to July of 2001. It is recommended that the HMO reconcile its reports and retain copies of such records pursuant to s. Ins 6.80, Wis. Adm. Code.

Reinsurance

The HMO does not maintain an aging of its reinsurance recoverables. Since the recoverable of \$44,289 is related to cases in 2000, it is assumed that the balances are over 90 days and should be nonadmitted. The amount of reinsurance recoverables is immaterial, therefore no adjustment will be made. It is recommended that the HMO maintain an aging of reinsurance recoverables for future annual statement filings.

Health Care Receivables

The HMO utilizes a Pharmacy Benefit Manager (PBM) for its prescription drugs. The examination reviewed the amount the HMO was reporting as a receivable for drug rebates. As part of the review, the examination requested an aging report of the rebates to determine compliance with SSAP No. 84. The finance department was not aware of any available aging

report. However, an aging report from the PBM that detailed amounts paid and amounts due was obtained from the medical director. The examination also noted that the PBM Agreement's timeline for payment of the drug rebates would not be in compliance with SSAP No. 84. The notes to the financial statements did not provide the proper disclosure for pharmaceutical rebates as noted in SSAP No. 84. It is recommended that the HMO establish a procedure for reporting pharmaceutical rebate receivable in compliance with SSAP No. 84.

Back-up Tapes

The HMO does not take its tapes off-site. In addition, the HMO does not retain a backup as of its financial statement dates. It is recommended that the HMO implement a process where its back-up tapes are taken offsite at least weekly and retain permanent copies of information at least annually.

Contingency Planning

The contingency plan is at the Prevea Clinic level and is limited to Information Technology. There was no evidence that there were department level detailed plans for disaster recovery or a listing of critical supplies and there was no evidence the plan was tested. With respect to disaster planning, the HMO has a number of clinics in the Green Bay area, so they would be able to set up the network at any one of them. From the perspective of the HMO, they only have 37 employees and finding alternative space would not be difficult. There was no discussion of the plan and integration with Trizetto in the event of a disaster. The actual processing of premium and claims is outsourced and covered by a separate plan with Trizetto. The HMO's access to Trizetto is separate from network access. It is recommend that the HMO should include business continuity/disaster recovery plans that address issues for each of the business functions and identify critical supplies and integrated with those of Trizetto in the event of a disaster. Further, it is recommended that an annual procedure to test the business continuity/disaster recovery plan should be developed.

Compulsory Surplus Requirement

As noted in the section of this report captioned "Financial Requirements," HMOs are required to maintain minimum compulsory surplus. The HMO's calculation as of December 31, 2001, as modified for examination adjustments is as follows:

Assets	\$15,214,738	
Less:		
Special deposit	415,000	
Liabilities	12,960,301	
Examination adjustments	<u>692,909</u>	
Total		\$1,146,528
Net premium earned	59,229,366	
Compulsory factor	<u>3%</u>	
Compulsory surplus		<u>1,776,881</u>
Compulsory Excess		<u>\$ (630,353)</u>

VIII. CONCLUSION

PHP Insurance Plan, Inc.'s 2001 annual statement reported assets of \$15,214,738, liabilities of \$12,960,301 and surplus of \$2,254,437. Operations for 2001 produced a net loss of \$1,103,937. This is the HMO's third consecutive year of net losses.

PHP went through several changes in its corporate and internal administrative structures during the examination period. A series of capital contributions and the issuance of new common stock over 2000 and 2001 changed the ownership of the plan. Prior to the examination period Wausau Service Corporation (WSC) owned one-third of PHP (f/k/a Prevea Health Insurance Plan, Inc.) and PHSI owned two-thirds. As of December 31, 2001, PHSI made the final stock transaction, which resulted in PHSI owning 100% of PHP.

As part of this restructuring, PHP contracted with Trizetto, an outside vendor, to provide administrative services as of July 2001. Previously these administrative services were provided by WSC. The change in administrators resulted in a claims backlog in 2001, which increased cash and claims payable considerably from 2000. The increase in claims payable was more significant because management took a more conservative approach in establishing IBNR (incurred but not reported claims).

The current examination resulted in thirty-three recommendations of which eight were repeated from the prior examination. The examination also noted several instances where the HMO failed to follow statutory accounting principles. Two reclasses were made in regards to affiliated balances. Surplus was decreased by \$692,909 due to nonadmitting certain affiliated receivables.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 23 - Management and Control—It is again recommended that the HMO submit biographical information on newly elected officers and directors in a timely fashion, as required by s. Ins 6.52 (5), Wis. Adm. Code. (Note: Subsequent to fieldwork the HMO submitted biographicals for all directors and officers.)
2. Page 23 - Management and Control—It is recommended that the HMO establish a procedure to file its information with the NAIC. (Note: Subsequent to fieldwork the HMO did submit the 2002 second quarter statement to the NAIC.)
3. Page 23 - Management and Control—It is recommended that the HMO establish procedures to submit the required filings to the OCI on a timely basis. (Note: Subsequent to fieldwork the second quarter statement for 2002 was received on time.)
4. Page 23 - Bylaws—It is recommended the HMO file changes to its bylaws with the OCI pursuant to s. 611.12(4), Wis. Stat. (Note: Subsequent to fieldwork the HMO filed the bylaws.)
5. Page 24 - Corporate Records—It is recommended that the HMO take minutes at Executive Committee meetings and retain such minutes as permanent records pursuant to s. Ins. 6.80, Wis. Adm. Code.
6. Page 24 - Territory and Operations—It is recommended that the HMO develop a procedure to ensure correct reporting of its service area.
7. Page 25 - Insolvency Protection—It is again recommended that the HMO comply with s. Ins. 9.04(6), Wis. Adm. Code.
8. Page 25 - Business Plans—It is recommended that the HMO file an amendment to its business plan within thirty-days of the adoption of this report.
9. Page 25 - Business Plans—Further, it is recommended that the HMO comply with business plan filings required by s. Ins. 9.06, Wis. Adm. Code in the future.
10. Page 26 - Holding Company—It is again recommended that the HMO comply with the requirements of ch. Ins. 40, Wis. Adm. Code.
11. Page 26 - Holding Company—It is recommended that the HMO comply with Form D filings in the future pursuant to s. Ins. 40.04, Wis. Adm. Code.
12. Page 26 - Holding Company—It is again recommended that the HMO properly complete Schedule Y in future statutory financial statement filings.
13. Page 27 - Affiliated Agreements— It is recommended that the HMO draft a formalized income tax allocation agreement with PHSI pursuant to SSAP No. 10 and file this agreement with the OCI pursuant to s. Ins 40.04, Wis. Adm. Code, within sixty days of adoption of this report.
14. Page 27 - Affiliated Agreements—It is recommended the HMO draft formalized agreements for services provided.

15. Page 27 - Affiliated Agreement—It is recommended that the HMO amend its Services and Equipment agreement with the Prevea Clinic in order to bring the transaction into compliance with s. 617.21, Wis. Stat.
16. Page 29 - Affiliated Transactions—It is again recommended that the HMO properly nonadmit amounts due from affiliates, as required by s. Ins 9.10, Wis. Adm. Code, in future statutory financial statement filings.
17. Page 29 - Affiliated Transactions—It is again recommended that the HMO timely settle affiliated balances, in accordance with the terms of its written agreements.
18. Page 29 - Financial Reporting—It is recommended the HMO properly complete schedules in accordance with the NAIC Annual Statement Instructions for Health Insurers on future statutory statements.
19. Page 30 - Cash—It is recommended that the HMO reconcile its general account and produce a list of outstanding checks to this office within 60 days of adoption of this report.
20. Page 30 - Cash—It is recommended that the HMO set up a procedure for keeping track of checks that could be escheatable under ch. 177, Wis. Stat.
21. Page 31 - Cash—It is recommended that the HMO comply with s. 601.23, Wis. Stat., by holding funds in its own name or under the terms of an acceptable custodial arrangement.
22. Page 31 - Cash—It is recommended that the HMO develop a plan that outlines how the HMO will comply with compulsory surplus requirements for future filings and file the plan with this office within sixty days of adoption of this report.
23. Page 32 - Investment Plan—It is recommended that the HMO finalize a formal investment plan that complies with state statutes and submit it to this office for review within 60 days of adoption of this report.
24. Page 32 - Premiums—It is recommended that the HMO discontinue the use of the FIFO method for applying cash received from groups as well as reconcile its billed amounts to amounts paid by its groups to determine the correct receivable balance and to properly age premiums receivable.
25. Page 32 - Premiums—It is recommended that the HMO discontinues using an allowance for doubtful accounts and nonadmit premium receivable balances over 90 days.
26. Page 33 - Premiums—It is recommended the HMO maintain proper premium records pursuant to s. Ins 6.80(4), Wis. Adm. Code.
27. Page 33 - Agents—It is again recommended that the HMO accept business only from properly listed agents pursuant to s. Ins 6.57 (5), Wis. Adm. Code.
28. Page 34 - Claims—It is recommended that the HMO reconcile its reports and retain copies of such records pursuant to s. Ins 6.80, Wis. Adm. Code.
29. Page 34 - Reinsurance—It is recommended that the HMO maintain an aging of reinsurance recoverables for future annual statement filings.

30. Page 35 - Health Care Receivables—It is recommended that the HMO establish a procedure for reporting pharmaceutical rebate receivable in compliance with SSAP No. 84.
31. Page 35 - Back-up Tapes—It is recommended that the HMO implement a process where its back-up tapes are taken offsite at least weekly and retain permanent copies of information at least annually.
32. Page 35 - Contingency Planning—It is recommend that the HMO should include business continuity/disaster recovery plans that address issues for each of the business functions and identify critical supplies and integrated with those of Trizetto in the event of a disaster.
33. Page 35 - Contingency Planning—Further, it is recommended that an annual procedure to test the business continuity/disaster recovery plan should be developed.

X. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the HMO is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, State of Wisconsin, participated in the examination:

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Respectfully submitted,

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